CENTER FOR AGING & COMMUNITY
901 S. Shelby Street Indianapolis, IN 46032 FAX (888) 841-0479

14 May 2010

Lidia Dubicki
Indiana Healthcare Associated Infection Initiative
University of Indianapolis
Center for Aging & Community

Ms. Dubicki:

We accept your offer to apply for participation in the Indiana Healthcare Associated Infection Initiative. Enclosed is our *Application for Participation Form*. We understand that this Initiative begins July 1, 2010 and continues through September 30, 2011. In applying for participation in this Initiative, we commit to participate in all activities and learning sessions. We further commit to tracking healthcare associated infections through the CDC National Healthcare Safety Network (NHSN) and making that data available to the collaborative for analysis and review.

We will make ourselves available for a phone call with application reviewers between May 17th and May 28th to clarify our application materials.

Regards,

Contact Information:

Signature

Administrator/CEO Signature

Phone: _____

Fax: _____

*Email: _____

Administrator/CEO Printed Name

Signature

Medical Director Signature

Phone: _____

Fax: _____

*Email: _____

Medical Director Printed Name

Signature

Director of Nursing Signature

Phone: _____

Fax: _____

*Email: _____

Director of Nursing Printed Name

***It is very important that you include correct email addresses.**
Email is the primary form of communication throughout this initiative.

Facility/Agency Name: _____

Street Address: _____

City State ZIP Code: _____

Must be faxed to Lidia Dubicki at
(888) 841-0479
(alternate FAX (317) 791-5945)
by May 14, 2010

Indiana State Department of Health

CAC University of Indianapolis
Center for Aging & Community

Indiana Healthcare Associated Infection Initiative

APPLICATION for PARTICIPATION

Name of Facility _____

Address of Facility _____

_____

_____

Primary Contact and Title _____

Phone Number _____

Email of Primary Contact _____

Proposed Members of Facility/Agency Team: Name and Email Contact Information

1 (Administrator/Nurse Administrator) _____

2 (Infection Preventionist) _____

3 (Licensed Direct Care Provider) _____

4 (Other Direct Care Provider – Aide or other Service Area) _____

5 (Other Pertinent Team Member) _____

What laboratory (or laboratories) does your facility/agency use?

Primary: _____

Secondary: _____

Do you currently or have you used the CDC National Healthcare Safety Network (NHSN) for healthcare associated infection data collection?

_____ Yes _____ No

Do you have high-speed (broadband) internet access for your facility or agency?

_____ Yes _____ No

Optional: You may attach a narrative to describe why your facility/agency is applying and what your facility/agency hopes to gain from participation.